WELCOME

1 about you

Today's Date:_____/_____/_____

Patient Name_____
LAST FIRST MI

What You Prefer to be Called_____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#:_____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ Ext._____

Cell Phone #: (_____)_____

How did you hear about us? ❑ Phone Book ❑ Radio
❑ Newspaper ❑ Friend/Family_____ ❑ Other_____

Employer: _____

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

2 account info

Person ultimately responsible for account

Name:_____

Relation:_____

Billing Address:_____

_____
CITY STATE ZIP

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am soley responsible for any balance not paid by my insurance company (if offered at this office).

3 insurance info

Primary Insurance

Co. Name:_____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____)_____

Insured's ID#:_____

Group # (Plan, Local, or Policy #)_____

4 contact info

In the event of an emergency, whom should we contact?

_____

Relation: _____

Cell Phone #:(_____) _____

Work Phone #:(_____) _____

Who is your Medical Doctor?

_____

Medical Doctor's Phone #:_____

Free Electronic Health Information

Health and Wellness Chiropractic sends out periodic electronic communications. Would you like to receive these communications?

❑ Yes ❑ No

Email: _____

please continue on back

5 reason for visit

Reason for today's visit: ❑ Emergency ❑ New Injury ❑ Old Injury ❑ Chronic Pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ____/____/____ Where did your injury occur?_____

Please explain what happened: _____

Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how:_____

_____

Has this or something similar happened in the past?

❑ Yes ❑ No When/How:_____

_____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No If so, where?

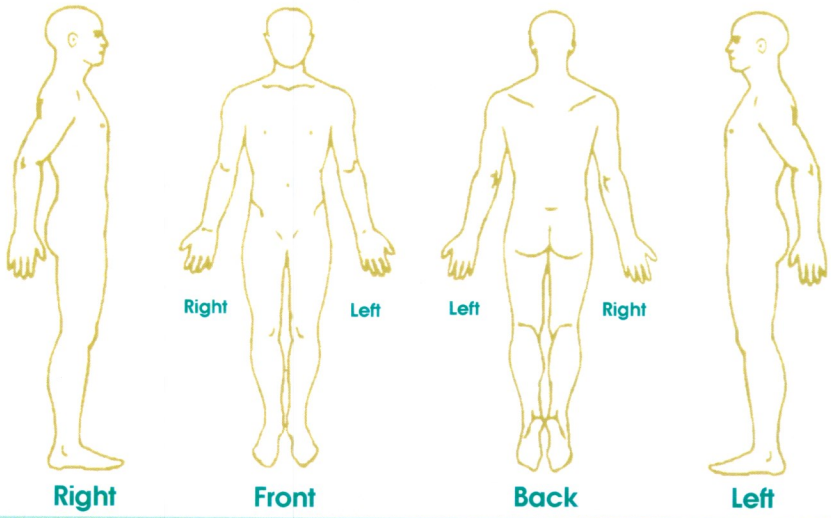
_____

Have you ever been treated by a Chiropractor?

❑ Yes ❑ No

Clinic or Doctor's Name: _____

Date of Last Visit:_____



6 health history

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s)_____

Do you have or have you had any of the following:

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+/AIDS/ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia/Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe/Frequent Headaches	Y N Kidney Problems
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis
Y N Recent Weight Change	Y N Bowel/Bladder Change	Y N Night Pain	Y N Cortizone Injection	Y N Recent Fever

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____

_____

Please list any past serious accidents with dates: _____

Please list anything that you may be allergic to:_____

Do you sleep on (check all that apply): ❑ Side ❑ Back ❑ Stomach

Family Health History: _____

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you Exercise? ❑ Yes ❑ No _____ hours per week

Do you smoke? ❑ Yes ❑ No How much?_____ How long?_____

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting? ❑ Yes ❑ No Since:___/___/___

For women: Are you taking Birth Control? ❑ Yes ❑ No

Have you ever been pregnant? ❑ Yes ❑ No Are you currently pregnant? ❑ Yes ❑ No If so, how many weeks?_____

Is there anything else you would like us to know? _____

Signature_____ **Date**____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

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